CRISIS LEAVE REQUEST FORM

MEDICAL CERTIFICATION

To be completed by employee:	
Employee's Name:	Personnel No.
Unit:	Job Title:
Telephone Number: ( )	Requested Number of Hours of Leave:
Requested Start Date of Leave:	Expected Date of Return to Work:
Reason for Request:	
Requested leave is to care for eligible family member: ☐ Yes ☐ No Name of Eligible Family Member: Relationship: NOTE: Additional information/documentation may be required by Crisis Leave Pool Manager/Committee in order to establish eligibility.	
Employee's Signature:	Date:
To be completed by Supervisor:	
Supervisor's Signature:	Date:
Recommendation: ☐ Approved ☐ Disapproved – Reason:	
To be completed by health care provider:	
Is this Condition: _____ Temporary _____ Permanent	
Date the Condition Began:	Anticipated Return to Work Date:
Description of Illness or Injury:	
Prognosis of Recovery:	
Health Care Provider's Address and Telephone Number:	
Health Care Provider's Signature:	Date:

Submit Completed Form To:
Leave Pool Manager, Office of Juvenile Justice, Human Resources Section
P.O. Box 66458 , Baton Rouge, Louisiana 70896